

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/24/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 297081		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/10/2009	
NAME OF PROVIDER OR SUPPLIER FIVE STAR HOME HEALTH CARE INC				STREET ADDRESS, CITY, STATE, ZIP CODE 3030 S JONES BLVD STE 108 LAS VEGAS, NV 89146			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
G 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 25418</p> <p>This Statement of Deficiencies was generated as a result of the Medicare re-certification survey conducted at your agency from 11/3/09 through 11/10/09, in accordance with 42 CFR Part 484 - Home Health Services.</p> <p>The active census on the first day of the survey was 184. Seventeen clinical records were reviewed, including one closed record. Seven home visits were conducted.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p>			G 000			
G 116	<p>484.10(f) HOME HEALTH HOTLINE</p> <p>The following regulatory deficiencies were identified:</p> <p>The patient has the right to be advised of the availability of the toll-free HHA hotline in the State.</p> <p>When the agency accepts the patient for treatment or care, the HHA must advise the patient in writing of the telephone number of the home health hotline established by the State, the hours of its operation, and that the purpose of the hotline is to receive complaints or questions about local HHAs. The patient also has the right to use this hotline to lodge complaints concerning the implementation of the advanced directives requirements.</p>			G 116			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 116	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interviews conducted during home visits, the agency failed to advise patients and/or families about the availability of the toll-free home health agency hotline telephone number for 2 of 7 patients (Patients #1.). Findings include: Patient #1 Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations. On 11/4/09 in the morning, Patient #1 indicated he was not informed regarding the toll free home health hotline number, "or if they did, I've forgotten about it."	G 116			
G 121	484.12(c) COMPLIANCE W/ ACCEPTED PROFESSIONAL STD The HHA and its staff must comply with accepted professional standards and principles that apply to professionals furnishing services in an HHA. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on Nevada Practice Act, review of clinical records, interviews and facility policy, the agency failed to ensure 1) field staff employed proper infection control and bag technique, and; 2) licensed staff identified themselves by their	G 121			

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G 121	<p>Continued From page 2 appropriate title in the clinical record.</p> <p>Findings include:</p> <p>Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations.</p> <p>On 11/4/09 in the morning, Patient #1 removed the dressing from dialysis access on the upper right arm and handed it to the Registered Nurse (RN) who was wearing gloves. The RN placed the old dressing into a trash bag.</p> <p>With the same gloves still on, the RN reached into the nursing bag for a thermometer. After using the temporal thermometer on Patient #1 ' s forehead and temple, the RN cleaned it with an alcohol pad, put it back into the nursing bag and retrieved an automatic blood pressure cuff while still wearing the original pair of gloves.</p> <p>After the RN obtained Patient #1 ' s blood pressure, she placed the cuff back into the nursing bag without cleaning it. The RN proceeded to check the patient ' s blood sugar level with the patient ' s glucometer while still wearing the original pair of gloves.</p> <p>After the RN checked Patient #1 ' s blood sugar level, the RN removed the gloves. Without performing any type of hand hygiene, the RN put on a new pair of gloves and performed wound care on the patient ' s right below the knee amputation site.</p>	G 121			

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G 121	Continued From page 3	G 121			
G 143	<p>The Nevada State Board of Nursing, Nurse Practice Act defined on page 50 of the September 2007 revision that: "632.249 Identification by appropriate title required..."</p> <p>1. Each registered nurse, licensed practical nurse, certified nursing assistant, nursing student and nurse certified in an advanced specialty shall identify himself by his appropriate title. (a) When recording information on a record.</p> <p>484.14(g) COORDINATION OF PATIENT SERVICES</p> <p>All personnel furnishing services maintain liaison to ensure that their efforts are coordinated effectively and support the objectives outlined in the plan of care.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418</p> <p>Based on record review and documented review, the agency failed to ensure all personnel furnishing service maintained communication and effectively coordinated care for ____ of 17 patients (Patients #1,</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations.</p>	G 143			

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G 143	Continued From page 4 Patient #1's clinical record for the certification periods of 7/17/09 through 9/14/09 and 9/15/09 through 11/13/09 were reviewed. The Skilled Nursing Visit Notes (SNVN) included an area in which the nurses could document "coordination with MD and/or other discipline." Most often, that line was left blank. The licensed practical nurse consistently documented "None" in the area.	G 143			
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview and clinical record review, the agency failed to ensure staff administered care in accordance with the plan of care established by the physician for ___ of 17 patients (Patients #1, . Findings include: Patient #1 Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations. The Plan of Care (POC) dated 7/17/09 through 9/14/09 included orders for Patient #1 to be seen by nursing every day for 60 days. During that 60 days, eight missed visit notes were completed.	G 158			

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G 158	Continued From page 5 The POC dated 9/15/09 through 11/13/09 was changed several times regarding visits. Five missed visit reports were completed up until 11/3/09. According to documentation in the clinical record, the physician was notified of two of the missed visits from the latest certification period. According to the agency's policy, CC-26 Delivery of Service, "... 5. In case a planned visit is missed, it shall be properly documented using a standard missed visit form and the office shall be notified."	G 158			
G 165	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Drugs and treatments are administered by agency staff only as ordered by the physician. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on clinical record review, the agency failed to administer drugs and treatments only as ordered by the physician for ____ of 17 sampled patients (Patients #1, Findings include: Patient #1 Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations. Patient #1's clinical record included a note dated	G 165			

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G 165	<p>Continued From page 6</p> <p>7/23/09, on which the Registered Nurse (RN) documented, "...blood sugar checked half way through dinner ...refuses to take the prescribed 10 units (U) of insulin. Requested 6 U of Novolog insulin - given aseptically SQ (subcutaneously) right abd (abdomen) tolerated well ..."</p> <p>Patient #1's Plan of Care (POC) for the certification period of 7/17/09 through 9/14/09 lacked orders for insulin. The Medication Profile (MP) dated 7/16/09 did not include insulin. There was no Telephone Communication/Physician's Order (TC/PO) indicating the patient was to take insulin.</p> <p>A TC/PO dated 8/24/09 indicated Patient #1 was to take Lomotil 2.5 mg one tablet by mouth after each loose bowel movement/as needed. The 7/16/09 MP was not updated to include the Lomotil.</p> <p>Patient #1's clinical record included a 9/12/09 written at 6:00 AM indicating, "SN (skilled nurse) to do daily wound care x (for) 2 weeks. Cleanse c (with) NSS (normal saline solution), pat dry, apply Accuzyme 10% and loosely cover ..."</p> <p>Patient #1's clinical record included a second 9/12/09 TC/PO written at 10:00 AM (to a different physician) indicating, "Continue SN visits, do daily wound care. Cleanse wound with NSS; pat dry, apply Accuzyme oint 10% and loosely cover ..."</p> <p>Patient #1's clinical record contained a skilled nursing visit note (SNVN) dated 9/13/09 and timed 12:30 PM, on which the nurse documented, "... cleansed with NSS, patted dry, applied Hydrogel and covered loosely ... "</p>	G 165			

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G 165	Continued From page 7 Patient #1's clinical record contained a SNVN dated 9/12/09 and timed 6:00 AM, on which the nurse documented, "... cleansed with NSS, patted dry, applied Hydrogel and covered loosely..." Patient #1's clinical record contained a SNVN dated 9/14/09 and timed 1:00 PM, on which the nurse documented, "... cleansed with NSS, patted dry, and covered loosely ..." Patient #1's clinical record included a 9/23/09 TC/PO written at 12:55 PM indicating, "Santyl ung (unguent) to wound QD (every day); SN to cleanse wound c (with) wound cleanser spray ... then apply Santyl ung and cover with DSD (dry sterile dressing) Q (every) SN visit ..."	G 165			
G 166	484.18(c) CONFORMANCE WITH PHYSICIAN ORDERS Verbal orders are put in writing and signed and dated with the date of receipt by the registered nurse or qualified therapist (as defined in section 484.4 of this chapter) responsible for furnishing or supervising the ordered services. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on record review and interview, the agency failed to ensure physicians' orders were signed and in the clinical record within 20 working days for ____ of 17 patients (Patients #1 ,).	G 166			

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G 166	Continued From page 8 Findings include: Patient #1 Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations. Patient #1's clinical record contained a Telephone Communication/Physician's Order, dated "09/ / /09 at 10:00 AM. On 11/5/09 in the afternoon, the medical records clerk was requested to check the tracking log to determine when this particular order for Patient #1 was written and when it was returned from being signed by the physician. According to the medical records clerk, this order for Patient #1 was written and went out for signature on 9/16/09 and was returned on 11/13/09.	G 166			
G 178	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse participates in in-service programs, and supervises and teaches other nursing personnel. This STANDARD is not met as evidenced by: Surveyor: 25418 Based on interview, record review and document review, the agency failed to ensure the licensed practical nurse was supervised by the registered	G 178			

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G 178	Continued From page 9 nurse every month for ____ of 17 patients (Patients #1 Findings include: Patient #1 Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations. According to documentation in Patient #1's clinical record, the licensed practical nurse (LPN) saw the patient 33 times over a 15 week period. The registered nurse (RN) saw the patient 29 times over the same time frame. Patient #1's clinical record lacked documented evidence indicating the RN performed a supervisory visit every month for the past two months. On 11/4/09, the Director of Professional Care Services (DPCS) indicated the documentation of supervisory visits should be in the clinical record. Patient #1's clinical record was opened to the tab labeled, "Supvr Visits." The section was empty. The agency's undated Policy #CC-08, titled Supervisory Visits of Field Staff reads, "...2.1 Licensed Practical Nurses will be supervised every month or according to state and/or local requirements..."	G 178			
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a review of all medications the patient is currently	G 337			

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G 337	<p>Continued From page 10</p> <p>using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.</p> <p>This STANDARD is not met as evidenced by: Surveyor: 25418 Based on review of clinical records, the agency failed to ensure the skilled nurse performed ongoing comprehensive assessments of all medications for ____ of 17 patients (Patients #1).</p> <p>Findings include:</p> <p>Patient #1</p> <p>Patient #1 was admitted on 5/18/09 with diagnoses including non-insulin dependent diabetes mellitus, hypertension and impaired mobility secondary to bilateral below the knee amputations.</p> <p>On 11/4/09 in the morning, during a home visit, Patient #1's medications were reviewed and compared to the latest Plan of Care (POC), dated 9/15/09 - 11/13/09, and a Medication Profile dated 7/16/09.</p> <p>Patient #1's MP did not include Loperamide and Aleve. These medications were presented by the patient and he indicated he took the Loperamide as needed for loose stools and the Aleve in the morning and at 3:00 PM every day for arthritis pain.</p> <p>Patient #1 had a prescription bottle of Lisinopril 20 milligrams (mg). The label read, "One tablet by mouth every day." The patient indicated he</p>	G 337			

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G 337	<p>Continued From page 11</p> <p>took this medication two times a day.</p> <p>Patient #1 indicated he was only taking a half and sometimes only one fourth of his Glipizide 5 mg, depending on the results of the blood sugar check. The patient indicated his physician was aware.</p> <p>Patient #1's clinical record included a Skilled Nurses Visit Note dated 7/23/09, on which the Registered Nurse (RN) documented, "...blood sugar checked half way through dinner ...refuses to take the prescribed 10 units (U) of insulin. Requested 6 U of Novolog insulin - given aseptically SQ (subcutaneously) right abd (abdomen) tolerated well ..."</p> <p>Patient #1's Plan of Care (POC) for the certification period of 7/17/09 through 9/14/09 lacked orders for insulin. The Medication Profile (MP) dated 7/16/09 did not include insulin. There was no Telephone Communication/Physician's Order (TC/PO) indicating the patient was to take insulin.</p> <p>A TC/PO dated 8/24/09 indicated Patient #1 was to take Lomotil 2.5 mg one tablet by mouth after each loose bowel movement/as needed. The 7/16/09 MP was not updated to include the Lomotil.</p>	G 337			